

The WHO directions on COVID-19 and Brazilian health public policies: an example of policy change?

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ABSTRACT

The paper first describes a brief history of the World Health Organization and its public actions during the last decades. It describes its organizational structure and its roles in global health governance. It also emphasizes some global WHO actions in this field. The objective is to show that WHO actions can be understood as part of the referential analysis of public policies, according to Jobert and Muller (1987). We then present the referential theory, and we describe how it can be used to understand the influence of international organizations in maintaining or changing specific paradigms in public policy. Afterward, we provide a brief history of Brazil's actions during the SARS H1N1 pandemic to illustrate how the WHO guidelines and the International Health Regulations have served as a paradigm for Brazilian public policy in this area. Then, we demonstrate that by not following the WHO recommendations to combat the pandemic, the Brazilian government generates a conflict of references expressed both in the clash between the central government and the Ministry of Health and in a federative clash opposing national and regional governments.

Key Words: WHO, International Health Regulations, Brazi, Covid-19.

INTRODUCTION

The relations established between States and International Organizations may result in the formulation (or reformulation) of public policies in the most diverse areas. It is possible to identify the international origin of the guidelines for elaborating or changing national public policies. The International Monetary Fund and World Bank's actions (in economics and education areas) are perhaps the best-known examples of this international influence. But they are not the only ones. We can name organizations that are part of the United Nations' governance system and international non-governmental organizations. The vital point to be highlighted is that even though public policies, defined as the State in action, are thought to be implemented from the national paradigm, their origins can be found outside the national limits.

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There is also the opposite movement when a successful national public policy spreads internationally.

Since its creation after the Second World War, the World Health Organization has established global objectives. In the 21st century, WHO sets global health goals, and its performance stands out amid the SARS pandemic and later COVID-19. A milestone in this performance was the Alma-Ata Conference, held in the Republic of Kazakhstan, then part of the Soviet Union, in 1978. The conference's result is contained in its declaration that establishes ten points to be followed by the member states. WHO is an intergovernmental organization, so the implementation of its resolutions depends on its member states' commitment. In the latter case, the Organization has suffered strong criticism for its performance, and many countries have challenged its legitimacy. Even so, the WHO guidelines and actions are referential for public health policies in many countries, including the COVID-19 pandemic. The purpose of this article is to investigate whether the WHO guidelines to combat COVID-19 were translated into public policies in Brazil and to what extent the federal government has followed them. Starting from the cognitive approach to the study of public policies, we intend first to investigate a previous reference for public health action to combat the pandemic.

The paper first describes a brief history of the World Health Organization and its public actions during the last decades. It describes its organizational structure and its roles in global health governance. It also emphasizes some global WHO actions in this field. The objective is to show that WHO actions can be understood as part of the referential analysis of public policies, according to Jobert and Muller (1987). We then present the referential theory, and we describe how it can be used to understand the influence of international organizations in maintaining or changing specific paradigms in public policy. Afterward, we provide a brief history of Brazil's actions during the SARS H1N1 pandemic to illustrate how the WHO guidelines and the International Health Regulations have served as a paradigm for Brazilian public policy in this area. Then, we demonstrate that by not following the WHO recommendations to combat the pandemic, the Brazilian government generates a conflict of references expressed both in the clash between the central government and the Ministry of Health and in a federative clash opposing national and regional governments.

1. World Health Organization: history and public actions.

The World Health Organization (WHO) is a specialized agency of the United Nations that acts as coordinating international public Health. Created on April 7, 1948, the agency inherited the mandate and resources of its predecessor, the Health Organization, which had been an agency of the League of Nations. Its objectives are to promote, for all people, the highest possible level of Health. Before commencement of work, its operations and other League of Nations of the Health Organization were under the control of an Interim Committee following an International Health Conference in New York in the summer of 1946. A resolution of the General Assembly

authorized the transfer. The Interim Commission of the World Health Organization received The epidemiological service of the International Office of Public Hygiene of France on January 1, 1947. Shortly after the end of World War I, the League of Nations was created to promote peace and security in the aftermath of the war. One of the League of Nations' mandates was the prevention and control of disease around the world. The League of Nations Health Organization was created for this purpose and had its headquarters in Geneva.

In 1945, the United Nations Conference on International Organization in San Francisco approved a motion presented by Brazil and China to establish a new, independent international organization dedicated to public health. In this way, WHO is part of the global governance system that emerged after World War II. The proposed Organization was intended to unite the number of disparate health organizations established in various countries worldwide. In its constitution, WHO defines Health as not just the absence of disease but a definition that later paved the way for WHO's involvement in the preventive aspects of the disease. Since its inception, WHO has been involved in public health campaigns that focused on improving health conditions. In 1951, the Fourth World Health Assembly adopted a WHO document proposing new international health regulations. In addition, WHO has mounted extensive vaccination campaigns against various microbial diseases, including polio, measles, diphtheria, whooping cough, tetanus, tuberculosis, and smallpox. This last campaign was highly successful, with the last known natural case of smallpox occurring in 1977. So, after two decades fighting smallpox, WHO declared in 1980 that the disease had been eradicated - the first disease eliminated by human effort.³

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³ WHO, About WHO, 2021.

1.1 Global Health Challenges

In the context of the pandemic, it is not the first time that the World Health Organization (WHO) responds to humanitarian emergencies. Previously, more than 60 million people, from West Africa to Iraq, were in urgent need of health services. In this sense, the Ebola outbreak in West Africa and the humanitarian crises ignited by the conflict in South Sudan, the Central African Republic, Syria, and Iraq, pushed health services to the limit and caused the collapse of many of them. This has required WHO and its health partners to fill ever-increasing gaps to ensure the rescue of millions of displaced people and the communities that host them.

Building on this collapse, WHO developed the Emergency Response Framework (ERF) to guide response in all types of emergencies. The ERF ensures that all of the Organization's resources support the answer to the most severe crises while simultaneously dealing with an unprecedented number of multiple humanitarian health crises. Moreover, the ERF helps manage concurrent emergencies with a broad degree of complexity, urgency and political, social, or economic impact, and long-term sustained crises, not just a time-limited outbreak period. In this way, the Organization acts as an articulator in formulating and implementing public policies developed in several of its member states.

WHO plays a dual role in humanitarian emergencies; on the one hand, it is the world's leading technical guidance that establishes authority over the range of health issues. On the other hand, it is the primary health agency in humanitarian crises, which involves an essential coordinating role as a leader in healthcare providers working in various emergency scenarios. This can mean anything from coordinating the execution of multiple health strategies in communities, such as immunization campaigns, to equipping health facilities, too, even in some situations, delivering essential health services. This role is increasingly crucial for WHO due to the decreasing number of health care providers working in emergencies. With the increase in security risks, especially for healthcare professionals, and with the increase in operations costs, many organizations that previously performed services in the country no longer do so. In this sense, the case of post-war Iraq is a revealing example, as the WHO-led health sector response involved only partner organizations working in the Water and Sanitation sector, along with mega emergencies and crises, including in Afghanistan, the Democratic Republic of Congo, Gaza, Mali, Pakistan, Ukraine, and Yemen, simultaneously. Thus, the Organization is characterized by being an international public policy actor capable of acting in multiple roles in multiple arenas.

Iraq. The WHO has worked effectively in multiple emergencies worldwide. For example, the Organization paid salaries for health workers in South Sudan to return to work. Or by purchasing large volumes of supplies for the Ebola outbreak to provide medicines and health services amid intense conflict in Syria and Africa. It is a fact that there was solidarity, generosity, and determined commitment from the international community to help those most in need of humanitarian health support around the world. (POZZATTI JUNIOR, 2019).

1.2 The Structure of the World Health Organization

From a structural point of view, WHO headquarters are in Geneva. WHO currently has 194 Member States, including all UN Member States except Liechtenstein, and two non-UN members, Niue and the Cook Islands. Territories that are not members of the UN can join as Associate Members (with complete information but with limited participation and voting rights) if approved by an Assembly vote: Puerto Rico and Tokelau are Associate Members.

WHO Member States nominate delegations to the World Health Assembly, the supreme decision-making body of WHO. All UN member states are eligible for WHO membership and, according to the WHO website, "Other countries may be admitted as members when a simple majority vote has approved their application of the World Health Assembly." Entities can also be granted observer status: examples include the Palestine Liberation Organization and the Holy See (Vatican City). The WHO Assembly generally meets in May of each year. In addition to appointing the Director-General every five years, the Assembly considers the Organization's financial policies and reviews and approves the proposed budget for the program. The Assembly elects 34 members, technically qualified in the health field, to the Executive Board for three-year terms. The board's primary functions are to carry out the decisions and policies of the Assembly, advise it, and facilitate its work in general. WHO is funded by contributions from State members and donors.

In recent years, WHO's work has involved more collaboration; there are currently about 80 partnerships with NGOs and the pharmaceutical industry and foundations such as the Bill and Melinda Gates and the Rockefeller Foundation. Voluntary contributions to WHO from national and local governments, foundations and NGOs, other UN organizations, and the private sector now exceed the assessed contributions (quotas) of the 194 member nations. The six WHO Regional Offices enjoy significant autonomy. Each Regional Office is headed by a Regional Director (RD), who the Regional Committee elects for five years, once renewable. The DR-elect is transmitted to the WHO Executive Board in Geneva, which proceeds to confirm the appointment. Each Regional Committee of WHO is composed of all heads of Health Departments in all the regional countries. In addition to electing the Regional Director, the Regional Committee is also responsible for establishing guidelines for the implementation of Health and other policies adopted by the World Health Assembly. The Regional Committee also serves as a board to review progress WHO actions within the Region. The Regional Director is effectively the head of WHO for his Region. The DR administers and supervises health personnel and other specialists at regional headquarters and in specialized centers.

1.3 Global Actions from Health for All and Primary Health Care

It is an indisputable fact that the widespread dissatisfaction with health services in the late 1960s and early 1970s led to an effort to find an alternative approach to standard health care, all set out in the joint WHO/UNICEF conference minutes held in 1979. The Health for All

(HFA) goal, adopted by member states at the 1977 World Health Assembly, required all people in the world to attain a level of Health that would enable them to lead socially and economically productive lives. In 1978, WHO and UNICEF co-sponsored the historical International Conference on Primary Health Care (PHC). The international development community embraced the PHC as the key to achieving "Health for All" by 2000. PHC, as defined at the Alma-Ata conference, called for a revolutionary redefinition of health care. Rather than the traditional "top-down" approach to medical service, it embraced the principles of social justice, equity, self-reliance, appropriate technology, decentralization, community involvement, intersectoral collaboration, and affordable cost. In this sense, the WHO effort to initiate a new management policy was notable (MATTA, 2005).

The Declaration on PHC provided for a minimum package of eight elements:

1. Education on prevalent health problems and methods of prevention and control
2. Promoting the provision of adequate food and nutrition
3. A good supply of potable water and basic sanitation
4. Maternal and Child Health, including family planning
5. Immunization against major infectious diseases
6. Prevention and control of locally endemic diseases
7. Proper treatment of common illnesses and injuries
8. Supply of essential drugs

Where appropriate, employing lay community health workers should be trained to handle specific tasks, including education, and provide first-level care, with appropriate referrals to secondary and tertiary health facilities.

Although some countries have successfully followed all of the PHC's precepts, it was the basis of the work philosophy for practically all subsequent international health activities. In the 1960s and early 1970s, community health workers and traditional midwives were grudgingly accepted by many, albeit only as second-rate health care providers, and despised by others, especially by some trained allopathic, conventional physicians.

As part of a global strategy for Health for All, in 1979, the World Health Assembly adopted the Global Strategy for HFA, which the UN General Assembly later endorsed. The UN resolution was the health community's attempt to mobilize the broader world community to

take collaborative action to improve the global health situation. The main thrust of the strategy was the development of a health system infrastructure, first with the PHC, to carry out nationwide programs that reached the entire population. The notion of primary health care or assistance must involve the adaptation conditions of each location (SCLiar, 2007). The successful example of "barefoot doctors" in China, PHC precepts, and programs has become respectable worldwide. It was conceived as a process that led to the progressive improvement of people's Health and not as a single finite target, although some indicators were recommended. It aims at social justice, with evenly distributed health resources and essential health services accessible to all, with full community involvement. While all member states voted to adopt the HFA via the PHC, implementation was long overdue as economic crises approached and political and military conflicts escalated. Natural disasters also intervened. The rapid growth of the urban poor and weaknesses in the Organization and management of health services have resulted in the waste and misuse of scarce resources. Above all, poverty and its unresolved root causes undermine many efforts in the slow march towards the HFA.

1.4 - WHO and the challenges in the 21st century

WHO maintains a network of collaborating centers, which are dedicated to working in various specific fields. She also holds a working relationship with a large number of non-governmental organizations involved in Health and development. These organizations are accredited and approved by the World Health Assembly.

In the second half of the 20th century, remarkable global health gains are observed, driven by rapid economic growth and unprecedented scientific advances. WHO played a crucial role in defining health policies and providing technical cooperation to its member states. But on the other hand, with the arrival of the COVID 19 pandemic, poverty is still spreading, with disparities in Health and wealth growing. Today more than a billion people are without the benefits of modern medical science, and one in five people in the world does not have access to safe drinking water. Considering the current crisis generated by the pandemic, we should note that the State has to oversee Health avoid a more significant crisis (GOMES, et al., 2018)

Another highlight is excessive consumption and pollution practices, which produce profound climate changes that impact the environment and the Health of human beings. The globalization of commerce and marketing has led to a sharp increase in tobacco, alcohol, and high-fat foods, along with unhealthy lifestyles, within this framework, WHO strategies as the UN's specialized health agency, its many effective programs, and policies at the global, regional, national, and community levels. Perhaps, above all, its humanitarian mission gives it international authority and guarantees it a central place. While it can be seen as the leading global health organization, it does not significantly impact Health. Like many transnational corporations and other global institutions, notably the World Bank and the International Monetary Fund, they have a growing influence on population health that surpasses that of WHO. (BRAGA et al., 2001)

In fact, from the 1980s onwards, the WHO gained competition from the World Bank in its actions for Health. According to Brown, Cueto, and Fee (2006), The Bank argues that both disease and malnutrition can be treated through the programs it develops. In these actions, the World Bank gave preference to free markets and minimized the role of national governments in Health. Also, this movement of the World Bank occurs just when the WHO begins to lose prestige. The overlapping of international organizations (WHO, World Bank, UNICEF) brought friction to international health governance. In a new neoliberal international paradigm, the World Bank best seized the opportunity to exercise leadership in international health governance.

An important step was the third elaborated revision of the International Health Regulations. The review intended to clarify the concept of PHEIC - a public emergency of international concerns. Its definitions are clear; "an extraordinary event which is determined, as provided in these Regulations: (i) to constitute a public health risk to other States through the international spread of disease and (ii) to require a coordinated international response potentially;" (WHO, 2005, Article I). Furthermore, the participating States commit to submitting information regarding possible PHEICs as soon as possible and as openly as possible. And the Director-General must determine, based on the information received, whether a specific event constitutes a public health emergency of international concern.

However, WHO has received criticism regarding the delay in enacting the PHEIC. According to a study by David N Durrheim, Laurence O Gostin, Keymanthri Moodley (2020), the Organization demonstrated an excessive delay in dealing with Ebola cases in the Democratic Republic of Congo in 2018. In addition, many denounced the lack of transparency in decisions and raised suspicions of political interference in decisions. For the authors, the PHEIC needs urgent reforms to achieve the goals set by the 2005 IHR.

2 - The Theoretical Approach

The COVID-19 pandemic has presented numerous challenges for national governments in implementing policies to combat the coronavirus and the WHO in formulating guidelines with this same objective. We defend that WHO guidelines can function as a public policy paradigm or referential. We also support that in one case, the SARS H1N1, the Brazilian government followed WHO guidelines as a reference to his public actions, and in the present case, the SARS COVID-19, the Brazilian government has not followed them primarily for ideological reasons. The primary guideline parameters had already been established in 2005 with the International Health Regulations.

The political sociology of public action (JOBERT AND MULLER, 1987) assumes that public policy analysis must be integrated into a broader conception of state-society relations. We intend to analyze this subject using the referential theory or the political sociology of public action, mainly its referential definition. Its composition is arranged in three elements: the sector-global relationship, the referential, and the actor's interaction dynamics involved in the power relations and regulation of a specific public policy.

The first one attempts to manage the relationship established between the sector considered in a specific public policy and the other government areas. Although the sector is public Health in the study presented here, sectorial-global relations happen in multiple arenas. Brazil is a federal state, and its public health system supposes inter-federal cooperation. Therefore, policy actions needed support and complementarity of the other government areas and subnational units. Subsequently, sectorial-global relations express how actors involved in public policy action articulate themselves. This relationship can also reveal the existing conflicts and power disputes inside public institutions. According to Jobert (1985, 2004), it is a mistake to consider the State as a unified and homogeneous entity and the public administration as a rational executor of governmental decisions. The various parts of government can represent, and often do, distinct, often complementary, and sometimes conflicting social and economic interests. In our particular case, we can observe the conflict between the President and State Governors and between the judiciary and the executive branches concerning COVID-19 combat actions.

The second key element is called a referential and covers norms, learning, and references expressed in a public policy. The referential can also be described as the representation made by the actors involved in this action. This representation is how various actors and social classes involved understand the origin, the development, and the possible unfolding of the problem to be the target of the State's action. It is also the expression of the perception of the government's role must play in that time. They are norms and references built by the actors involved through their relationships, interactions, consensus constructions, and decisions. To know how the referential is elaborated is to understand how the actors themselves see their respective roles,

functions, values, and interests. We know the referential as a representation of global-sector relations in public policy. The referential might determine the social and geographical extension of a public policy. In this paper, we also consider the referential as a paradigm of public policies. Besides, the paradigm for public actions in the pandemia cases is the international regulation approved by the World Health Organization.

The third key element is concerned with the actors who work in the construction of the referential. The set of actors encompasses the various state actors, local, regional or national, and non-state actors and international actors. The interaction dynamic among these actors is the essential aspect here. The policy decisions being the result of this interaction dynamic played by the different actors. New political relations (be cooperation ones, be conflicting ones) might emerge depending on the actor dynamics interaction.

We should understand the three key elements according to action cycles. Müller (2015) and Faure and Müller (2013) define the cycles as social configuration processes determining the State's role in public policy actions. They identify four cycles: i) the industrial liberal, ii) the welfare state, iii) the state-enterprise, and iv) sustainable governance. Each cycle corresponds to different economic, citizenship, and public policy regimes that express the referential in which the State is inserted. In the Latin American case, the cycles refer to other political forces acting in public policies. Brazilian republic history alternates between democratic and authoritarian regimes. And in both cases, the State's role has been crucial to all public policies. The Brazilian case relies on nowadays a cycle of economic crisis and social background favorable for populist governments.

Concerning the possible changes in public policy, the Advocacy Coalition Framework has been used to describe and analyze them. According to Pierce, Peterson, and Hicks [14], this approach contributes to understanding the decision-making processes of changes in public policies. Advocacy coalition is a specific form of collective action to shape and change public policy even within closed political regimes. It is based on the interaction of actors in the political subsystem; it differs from social movements, interest groups, or political parties [16]. There are three steps to understanding policy change: the first is its process requires a time perspective of at least a decade. Second, a policy change study should focus on policy subsystems, which are the actor's interactions in a specific area of public policy. Third: public policies can work as belief systems, which are "[...] assets of value priorities and causal assumptions about how to realize them" (Idem, 1988, 131). Sabatier and Weible (1988) also stressed:

The importance of the context in which coalitions operate.

1. A typology of coalition resources.
2. New paths to policy change.

The context is vital because the ACF was a successful use in understanding pluralist regimes, but it can also explain changes in the institutional context of developing countries. The typology of coalition resources is a complement of the belief system approach. A robust belief system can only engage in policy change if it has the needed resources to act. Finally, the ACF's two new paths to policy change analyses are 1) internal shocks and 2) negotiated agreements. Initially, the ACF focused on external shocks as a needed cause for policy change. However, this focus was not enough to comprehend policy changes originating from internal political demands or changes in the dominant coalition.

2,1 The PHEIC (Public Health Emergency of International Concern): an international referential to public policies

In the present case, an external shock came: the COVID 19 pandemic. The shock is not limited to the public health subsystem; it strongly affects its economic, political and social life. There was a change in public policies due to the pandemic exceptionality, or the exceptionality was already foreseen within public health policies. For example, coping actions had been outlined years ago due to the SARS pandemic at the beginning of the 21st century. The third edition of the International Health Regulations (2005), published by the WHO, already contains the protocols for applying and implementing the PHEIC - public health emergency of international concern. According to the document, the first adoption of the International Health Regulations was in 1969. It was a new version of the regulations approved at the Fourth World Health Assembly in 1951. It was modified in the years 1973 and 1981. And finally:

After extensive preliminary work on the revision by WHO's Secretariat in close consultation with WHO Member States, international organizations, and other relevant partners, and the momentum created by the emergence of a severe acute respiratory syndrome (the first global public health emergency of the 21st century), the Health Assembly established an Intergovernmental Working Group in 2003 open to all Member States to review and recommend a draft revision of the Regulations to the Health Assembly. The Fifty-eighth World Health Assembly adopted the International Health Regulations (2005) on 23 May 2005. They entered into force on 15 June 2007. (WHO, 2005, 01).

The new regulation was a response to SARS cases in the early years of the 21st century. When the H1N1 pandemic emerged, the WHO already had a response system to reference the public actions needed to control that pandemic. The signatory states of the IHR agree to put into action the protocols relating to the PHEIC as part of their public health policies.

As Ferreira and Castro (2012) demonstrate, Brazil incorporates in its legal system the guidelines of the World Health Organization for the New International Health Regulation through Legislative Decree 395 of July 9, 2009. The New Health Regulation would conform to the requirements of a globalized world where the spread of disease occurs faster. The Brazilian government made use of these guidelines (PHEIC) in its policies to combat the H1N1 Influenza Pandemic in 2009. Even before the outbreak of this pandemic, the government had already drawn up a preparedness plan—public actions implemented through federative cooperation that governs the SUS. In a publication by the then Minister of health José Gomes Temporão (2009), the articulation between the State and municipal health secretariats and the WHO guidelines are highlighted, functioning as a reference for establishing public policies to fight the pandemic of the new H1N1 influenza virus. Bellei and Melchior (2011) support the description of vaccination in the case of H1N1 in Brazil, following the WHO recommendations.

3 - the Brazilian case

By putting into action the three key elements of public policies, we have the following scenario: the sectoral-global relationship presents, on the one hand, a conflict between the Ministry of Health and the health system with the presidency of the republic, on the other hand, a conflict between the federal executive and State governors. All the articulation marks the sectoral-global relationship of public policy to combat COVID-19 is taken up by these conflicts. Since the beginning of the pandemic, the country is already in its fourth health minister. The first, the politician and doctor, Luis Mandetta, was sent away for disagreeing with the Republic's President regarding the quarantine and social isolation policies. The second minister, physician Nelson Teich, came from the private sector and had no experience working in the public area. His stay was approximately one month, and his departure was due to differences in the conduct of isolation, quarantine, and treatment of the pandemic. The Minister who most remained in office was a General with no experience in public health administration but who obeyed the commands given by the President. It was during his administration that the ministry started to recommend drug treatment without proven scientific efficacy. It was the period of most incredible friction with state health secretaries and governors. Much federal government's requests to suspend measures to combat COVID, implemented by state governors, were denied by the country's supreme court.

The number of dead and infected fell at the end of 2020 to go back to advance and find a new peak in the first months of the year 2021. Another minister of Health was appointed. The conflicts even took place in the vaccine issue; while the federal government was delaying the purchase of vaccines, the State of São Paulo began to produce them in partnership with a Chinese pharmaceutical company. Thus, the sectoral-global relationship came to encompass not only conflicts of interest or overlapping areas of government or part of the population; the relationship began to be shaped and shaped according to the clash of narratives in a fragmented and polarized political environment. In April 2021, the Federal Senate created a parliamentary inquiry commission to investigate the federal government's negligence in dealing with the pandemic and the delay in purchases of the vaccine.

The federal government issued 3,049 regulations related to COVID-19 in the year 2020, according to the Pandemic Rights bulletin (2021). For the authors, the excessive number of norms confirms that they lack rights where they, the standards, exist in excess. This excess would be the expression of the conflict between the federal government's strategy, on the one hand, and the state governments and the judiciary on the other. Furthermore, the National Contingency Plan for Human Infection by the new Coronavirus COVID-19 (Ministry of Health, 2020) did not include any reference to human rights as required by Brazilian law and the International Health Regulations. There are strong indications that the federal government did not act to contain the virus, believing that the economic recovery would be faster in this way (BOLETIM Direitos na Pandemia, 2021).

As far as the analysis of the second key element, the referential, is concerned, it appears to reflect the conflict described above. We started from the premise that WHO guidelines, such as the IHR and the PHEIC, had already been constituted as a paradigm in Brazil. Thus, we could compare the current government's actions with the existing benchmark to highlight their differences. However, what happens is that the steps coming from the republic's presidency are more than a paradigm shift; they are its denial. Currently, the activities of the Ministry of Health seek to balance the demands for the end of restrictions coming from the federal government and the need to contain the transmission of the virus and the Organization, through federative cooperation, of a national immunization plan.

Regarding the interaction dynamics of political actors, it oscillates between cooperation between subnational units, which continue to be related to the IHR guidelines, with possible participation of the Ministry of Health and the Unified Health System - SUS and open conflict with the government federal. According to Abrúcio, Grin, Franzese, Segatto, and Couto (2020), the federative dynamics during the current period is a confrontation of two federative models: the first based on cooperation with federal coordination following the 1988 Constitution and the second based on a centralizing and hierarchical in national issues and dualist in intergovernmental matters, reducing the union's participation in helping its subnational federated entities.

At this point, it is possible to recover the approach of the Muller and Faure cycles to understand this reality. If cycles reveal how societies see themselves and imagine their future, how to describe the cycle in a divided and polarized society? The country is in a cycle of strengthening populism in a global context of attacks on democracy and strengthening fascist political positions (Levitsky and Ziblatt, 2018; Stanley, 2018; Mounk, 2018). Furthermore, there is also an attack on the progress of the Enlightenment, something that Bobbio had already noticed (1994) in the Italian extreme right at the end of the last century. The conflicts that arise through federalism are conflicts between authoritarian and democratic paths. The populist cycle intensifies the conflict by making the simplistic division of reality and transforming science into a discourse.

Final considerations

The article intended to demonstrate that the work of the World Health Organization can function as a reference for public health policies. And this demonstration exposes the fact that the Brazilian government, in the case of COVID-19, did not take the Organization's guidelines as its reference point as it had done in the cases of previous epidemics.

A brief history of the World Health Organization's performance was exposed, from its early days to the current challenges, highlighting its main contributions to global health construction, such as the International Health Regulations and the PHEIC - public health emergency of international concerns. Although WHO's actions have been criticized, as in the Ebola epidemic in Africa, the Organization remains the global health paradigm.

We also expose the referential theory as the approach that allowed us to understand better the reality of federative conflict, lack of leadership, and populism context that characterize the pandemic reality in Brazil.

We conclude that the conflict between two types of federalism, the first enshrined in the 1988 Constitution and based on the cooperation of federative entities, and the second centralized and without space for dialogue, represent willingness for different paths for Brazil. The first seeks to preserve rights and democratic order, and the second openly flirts with populist authoritarianism.

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